What's New?

COBRA FY08/09

Open Enrollment
May 5th thru May 16th

MARICOPA COUNTY
1871
ARIZONA

Employee Health Insurance Program

What are the "Right" plans for you?

ellii
EMPLOYEE HEALTH INITIATIVES

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GLOSSARY OF TERMS

CIGNA Care Network (CCN): A high performing cost effective specialty care provider network that includes the following provider specialties: allergy/immunology, pulmonology, vascular surgery, cardiology, neurosurgery, orthopedics and surgery, urology, general surgery, ear, nose and throat, ophthalmology, rheumatology, infectious disease, gastroenterology and dermatology. These providers are identified by a Tree of Life Symbol in the CIGNA provider directory.

CMG (CIGNA Medical Group Network): A network of providers who are employed by CIGNA HealthCare of AZ who practice in the CMG facilities that are owned and operated by CIGNA. Primary and some specialty and ancillary care are provided at the CMG facilities. Some specialty care is provided through the OAP network when a referral is made by the CMG physician.

CMG High and Low Plan: A managed-care plan that requires members to use the CMG facilities for primary and most specialty and other services. Use of non-network providers or providers who practice in their own offices are not covered.

Co-insurance: A cost-sharing requirement under a health insurance policy, which provides that the insured will assume a percentage of the costs of covered services after payment of the deductible, if applicable.

Copay: A cost-sharing arrangement in which the insured pays a specified flat dollar amount for a specific service (such as $20 for an office visit). The amount does not vary with the cost of the service, unlike co-insurance, which is based on a percentage of cost.

Deductible(s): Under a health insurance policy, amounts required to be paid by the insured either before benefits become payable, after a portion of benefits have been paid or for a specific benefit, before benefits are payable.

Health Maintenance Organization (HMO): HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals and other health professionals, who participate in their network. The members of an HMO are required to use participating network providers for all health services, and many services must meet further approval by the HMO through its utilization review program. HMOs are the most restrictive form of managed care benefit plans because they manage and restrict the procedures, providers and benefits.

Health Savings Account: A tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan.

High Option: A plan where premiums are higher than a low option plan because the insured shares less of the costs with lower copays.

In-Network (or Network, Participating Provider): Health care provided by a doctor, hospital, pharmacy or other health care provider with whom the plan has contracted to provide services at specified fees.

Insured: A person or organization covered by an insurance policy.

Insurer (Insurance Company or vendor): A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

Low Option: A plan where premiums are reduced in comparison to a high option plan because the insured shares more of the costs in the form of higher copays and co-insurance.

OAP (Open Access Plus) Plan: A plan that gives options to use a network or non-network physician/provider each time the insured needs medical care, and does not require a referral to see a specialist.

OAPIN (Open Access Plus) In-Network: A plan that uses a network of providers who practice in their own offices and independently contract with CIGNA. Non-network physicians/providers are not covered under this plan. The OAP In-Network also includes the CMG network. A referral is not required to see a specialist.

Out-of-Network (or Non-Participating, Non-Network Provider): Health care received from a provider who is not contracted with the insured's health plan network.

Out-of-Pocket Maximum: The maximum amount the insured pays each year for health care. The maximum may apply only to specific services such as inpatient hospitalizations. After this share of eligible expenses has reached the plan's out-of-pocket maximum per person or per family, the plan pays the full cost of eligible expenses for the rest of that plan year. The out-of-pocket maximum does not include any copays, pharmacy or mental health/substance abuse treatment expenses, or non-certification penalties. Each plan summary lists the expenses that count towards the out-of-pocket maximum.

Plan Year: July 1 through June 30

Preferred Medication List (aka Formulary): List of prescription drugs approved by a pharmacy benefit manager. Drugs on the preferred medication list are generally more cost effective and are as effective as other drugs that are non-preferred in the same therapeutic medication class. The list is available at ***www.maricopa.gov/benefits***.

Preventive Care Services: This includes all routine preventive services such as Well Baby Care, Well Child Care and Adult Preventive Care as identified by each plan in the plan summary.

Primary Care Physician (PCP): A physician who practices general medicine, family medicine, internal medicine or pediatrics.

Reasonable and Customary Charge (R&C): The prevailing charge of most other providers in the same or similar geographic area for the same or similar service. If the insured receives out-of-network services and the provider's fee is more than the R&C charge, the insured will have to pay the amount of charges above R&C. When care is received from an in-network provider, the eligible expenses are determined from the network provider's contracted rate.

Specialty Medication: Usually are expensive drugs (oral or injectable) that are used to treat complex and rare medical conditions. These drugs may require special care and handling (such as refrigeration) and patient counseling due to their high risk of causing serious side effects or complications.

GLOSSARY OF ACRONYMS

Abbreviations used throughout this booklet

C
CCN: CIGNA Care Network
CMG: CIGNA Medical Group
COBRA: Consolidated Omnibus Budget Reconciliation Act

E
EDS: Employers Dental Services
EE: Employee
EHI: Employee Health Initiatives

H
HIPAA: Health Insurance Portability and Accountability Act
HMO: Health Maintenance Organization
HSA: Health Savings Account

I
ID: Identification
IRC: Internal Revenue Code
IRS: Internal Revenue Service

M
MH: Mental Health
MST: Mountain Standard Time

O
OAPIN: Open Access Plus In-Network
OAP: Open Access Plus
OE: Open Enrollment

P
PCP: Primary Care Physician
PHI: Protected Health Information
PML: Preferred Medication List
PPO: Preferred Provider Organization
PSPRS: Public Safety Personnel Retirement System
PST: Pacific Standard Time

R
RX: Prescription

S
SPD: Summary Plan Document
SSN: Social Security Number

U
UV: Ultraviolet

W
WHI: Walgreens Health Initiatives

WHAT'S NEW?

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009

CIGNA MEDICAL PLAN CHANGES

Changes to the medical plan offerings and copayments are listed below.

CMG (CIGNA Medical Group) High Option changes		
Service	Copay	Change
Preventive Care	$0	Was $15 / $25
Allergy Injections	$8* / $23	Was $25
Specialty Care	$25* / $40	No change / Was $25
Emergency Room	$125	Was $75

CMG (CIGNA Medical Group) Low Option changes		
Service	Copay	Change
Preventive Care	$0	Was $25 / $45
Allergy Injections	$13* / $28	Was $45
Specialty Care	$45* / $60	No Change / Was $45
Emergency Room	$125	Was $100

OAPIN (Open Access Plus In-Network) changes		
Service	Copay	Change
Preventive Care	$0	Was $20 / $30
Allergy Injections	$10* / $25	Was $30
Specialty Care	$30* / $45	No Change / Was $30
Emergency Room	$125	Was $100

OAP (Open Access Plus) High Option changes		
In-Network Service	Copay	Change
Preventive Care	$0	Was $25 / $35
Allergy Injections	$13* / $28	Was $35
Specialty Care	$35* / $50	No change / Was $35
Emergency Room	$125	Was $100

OAP (Open Access Plus) Low Option changes		
In-Network Service	Copay	Change
Preventive Care	$0	Was $35 / $50
Allergy Injections	$18* / $33	Was $50
Specialty Care	$50* / $65	No change / Was $50
Emergency Room	$150	No Change

Choice Fund HSA (Health Savings Account) changes		
	In-network & out-of-network	Change
Single Coverage	$2,000	Was $5,000
Other Coverage Levels	$4,000	Was $10,000

WHAT'S NEW? continued

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009

Preventive Care Services - $0 Office Visit Copay

This only applies to in-network services and includes the following:

- Routine Preventive Care for children and adults
- Routine Immunizations
- Routine Mammograms, PSAs, and Pap Smears

**CIGNA Care Network Specialist - Specialty Care Services - $15 Office Visit Copay Differential*

When selecting in-network Specialty Care through a CIGNA Care Network (CCN) provider, the office visit is offered at a lower copayment. The CIGNA Care Network is a high-performing cost-effective specialty care network that meets certain criteria related to quality and efficiency. The CCN includes the following provider specialties: allergy/immunology, pulmonology, vascular surgery, cardiology, neurosurgery, orthopedics and surgery, urology, general surgery, ear, nose and throat, ophthalmology, rheumatology, infectious disease, gastroenterology and dermatology. CCN providers are identified by a Tree of Life Symbol when you go online to ***www.cigna.com*** to search for a provider. This office visit copayment differential does not apply to the CIGNA Choice Fund HSA plan.

Durable Medical Equipment – No Annual Limit

For in-network services, there is no annual limit for Durable Medical Equipment. All Durable Medical Equipment must be medically necessary and a prior authorization is required for certain equipment.

Allergy Injections – Lower Office Visit Copay

For in-network services, a lower office visit copay applies for Allergy Injections administered by your Primary Care or CIGNA Care Network (CCN) Specialty Care Provider. Allergy Injections received from a non-CCN Specialty Care Provider are $15 higher. This lower office visit copay does not apply to the CIGNA Choice Fund HSA plan.

Choice Fund Health Savings Account Plan

Cross Accumulation for deductibles and out-of-pocket maximums

If a service is received in-network or out-of-network, the covered costs will be applied to both your in-network and out-of-network deductible and out-of-pocket maximums.

Out-of-pocket maximums reduced

Reduced the out-of-pocket maximums from $5,000 to $2,000 for single coverage and from $10,000 to $4,000 for all other coverage levels.

PHARMACY PLAN CHANGES

Delivery of Specialty Medication

Specialty medication will be delivered only through Walgreens Specialty Pharmacy, a centralized mail order distribution center. Walgreens Specialty Pharmacy offers personalized care from an experienced Care Team of pharmacists and nurses trained in the complex health conditions and the latest medication therapies. A wide range of support services will be available to assist you with your specialty medication needs. Through these support services, you will receive personalized support that can help you get the best results from your prescribed therapy. These services are available to you at no cost. Employees and/or dependents impacted by this change will receive a letter in May 2008.

Changes that apply to the Co-Insurance Pharmacy Plan

Non-Sedating Antihistamine (NSA) Step Care Therapy Program

A Non-Sedating Antihistamine Step Care Therapy Program will be implemented. This program includes the following non-sedating antihistamine (NSA) medications: Allegra, Allegra-D® 12 Hour, Allegra-D® 24 Hour, fexofenadine, Clarinex®, Clarinex-D® 12 Hour, Clarinex-D® 24 Hour, Clarinex-D® Redi-Tab, or Xyzal®. This Step Care Therapy Program requires you to first try the over-the-counter options—Claritin (loratadine) and Zyrtec (cetirizine)—before filling a prescription for a NSA medication. In many cases, these over-the-counter NSA medications are as effective as the prescription NSA medications, and cost less for you and your dependents.

If you or your dependents have already tried an over-the-counter NSAs and your doctor says you require a prescription NSA, please call the WHI Clinical Call Center at (877) 665-6609, Monday through Friday, 8:00 AM - 8:00 PM CDT, to start the prior authorization process. Employees who are impacted by this change, will receive a letter by June 2008.

Xyzal® will be considered Tier 3 or Non-Preferred Brand

In addition, Xyzal® will be considered Tier 3 or non-preferred brand on the Preferred Medication List (PML) and will be subject to the highest co-insurance level. A 30-day supply of a non-preferred drug with no generic equivalent such as Xyzal will have a 50% co-insurance. The lower cost, Tier 1, generic alternative is fexofenadine.

WHAT'S NEW? continued

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009

DENTAL PLAN CHANGES

CIGNA Dental Progressive/Regressive Feature

The CIGNA Dental plan will be enhanced to include a progressive/regressive wellness incentive that will apply to dental services provided in-network and out-of-network. Preventive care services received in one plan year are rewarded with higher benefit percentages the next plan year. The benefit level increases year after year as employees and/or dependents receive preventive care. When preventive care is not received, the benefit percentage decreases in the following year; however, the benefit percentages will never fall below the base plan design which is effective 07/01/08.

The plan is designed to encourage good dental care for you and/or your dependents. Therefore, the increase/decrease (progression/regression) in benefit is tracked at an individual member level and the increase only applies to those family members that receive Preventive Care Services.

The base plan summary by class for Year One, effective 07/01/08, is defined below. For a detailed benefits summary, please turn to page 19.

Year One - Effective 7/01/08 - Base Plan

	In-Network		Out-of-Network	
Benefit Level	Plan	Employee	Plan	Employee
Class I - Preventive & Diagnostic Care	100%	0%	80%	20%
Class II - Basic Restorative Care	**80%**	**20%**	**60%**	**40%**
Class III - Major Restorative Care	**50%**	**50%**	**50%**	**50%**
Class IV - Orthodontia	50%	50%	50%	50%

Progressive Feature

Preventive Care Services (Class I) received in Year One are rewarded with high benefit percentages for Basic Restorative Care (Class II) and Major Restorative Care (Class III) for both in-network and out-of-network services. Progression increments are 5% per year and will not exceed the maximum benefit level in Year Three, which is 90% (in-network) and 70% (out-of-network) for Class II and 60% Class III (in- and out-of-network).

For example, if you receive Preventive Care Services (Class I) during Year One (Base Plan), your plan design for Year Two is defined below:

Year Two - Effective 7/01/09

	In-Network		Out-of-Network	
Benefit Level	Plan	Employee	Plan	Employee
Class I - Preventive & Diagnostic Care	100%	0%	80%	20%
Class II - Basic Restorative Care	**85%**	**15%**	**65%**	**35%**
Class III - Major Restorative Care	**55%**	**45%**	**55%**	**45%**
Class IV - Orthodontia	50%	50%	50%	50%

If you receive Preventive Care Services (Class I) during Year Two, your plan design for Year Three is defined below:

Year Three - Effective 7/01/10

	In-Network		Out-of-Network	
Benefit Level	Plan	Employee	Plan	Employee
Class I - Preventive & Diagnostic Care	100%	0%	80%	20%
Class II - Basic Restorative Care	**90%**	**10%**	**70%**	**30%**
Class III - Major Restorative Care	**60%**	**40%**	**60%**	**40%**
Class IV - Orthodontia	50%	50%	50%	50%

WHAT'S NEW? continued

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009

Regressive Feature

When Preventive Care Services (Class I) are not received, the benefit percentages for Basic Restorative Care (Class II) and Major Restorative Care (Class III) will decrease the following year. Regression decrements are 5% and will not fall below the Base Plan Year.

Illustrations

Below are 3 different illustrations:

ILLUSTRATION 1

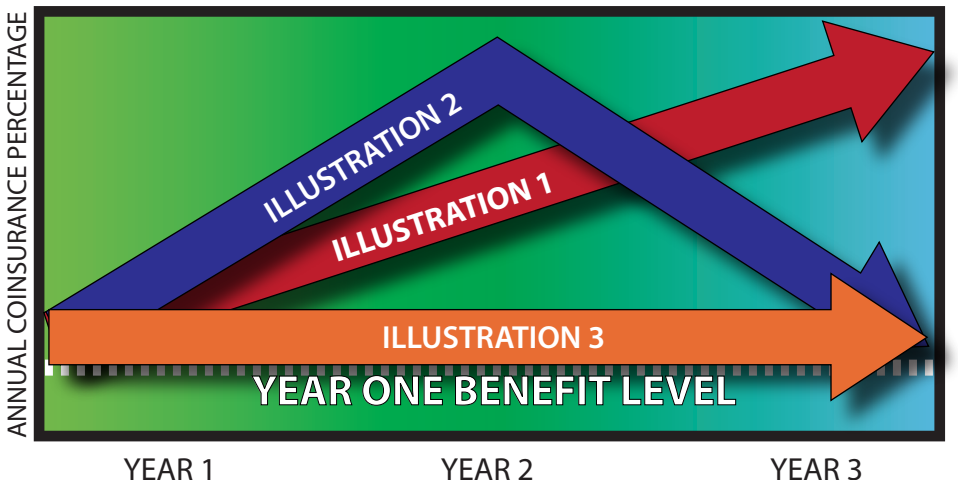
If you receive preventive care every plan year, your benefit level will increase the following plan year until it reaches the maximum level - year 3.

ILLUSTRATION 2

If you receive preventive care in plan year 1, your benefit level will increase in year 2. If you do not receive preventive care in year 2, your benefit level in year 3 will return to year 1 benefit level.

ILLUSTRATION 3

If you never receive preventive care, your benefit level will remain the same and never decrease below your base plan year.



PREMIUM RATE CHANGES

The premium discount has been increased from $20.00 to $30.60 per month for non-tobacco using households (employees and their dependents). Households where either the employee and/or a covered dependent uses tobacco-products, do not qualify for the discount and will be charged a premium rate that is $30.60 per month higher.

QUESTIONS?

Refer to the contact information page provided at the end of this booklet

Call the Employee Health Initiatives Department at

(602) 506-1010 from 8 AM to 5 PM Monday-Friday for benefit questions.

OPEN ENROLLMENT PERIOD

This Open Enrollment period, your benefit elections and premium rates are effective for a 12-month period, beginning July 1, 2008 and ending June 30, 2009. The next time you can change your benefits will be the next Open Enrollment in May 2009.

WHEN?

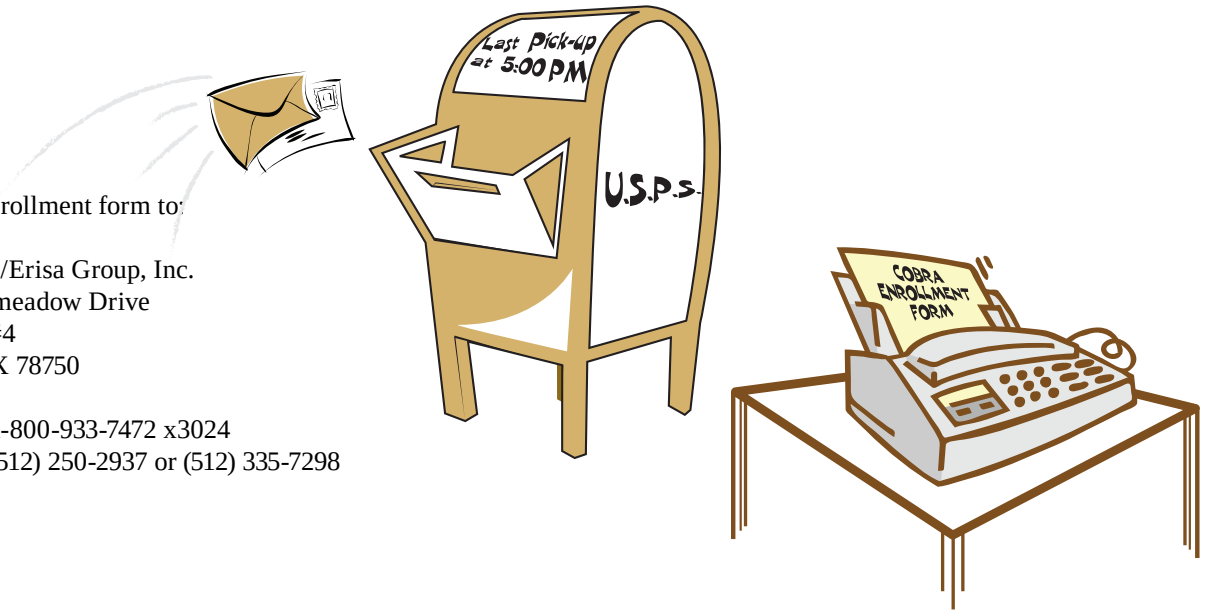
Open Enrollment begins Monday, May 5, 2008 through Monday, May 16, 2008
Enrollment forms must be mailed or faxed to Compusys no later than May 16, 2008. Forms delivered by U.S. Postal Service must be postmarked by May 16, 2008. **Late enrollments will not be accepted.**

HOW?

Mail or fax your enrollment form to:

Compusys/Erisa Group, Inc.
12325 Hymeadow Drive
Building #4
Austin, TX 78750

Phone: 1-800-933-7472 x3024
Fax: (512) 250-2937 or (512) 335-7298



WHERE DO I GET ADDITIONAL INFORMATION NOT CONTAINED IN THIS GUIDE?

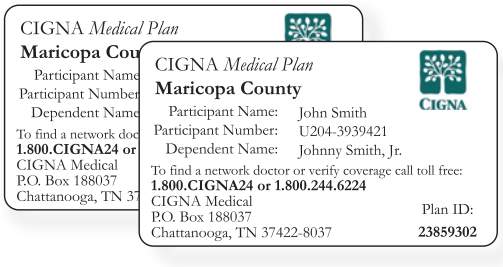
While most of the information you need is contained in this guide, other pertinent information is available online at the Benefits Home Web site located at ***www.maricopa.gov/benefits***. The Benefit vendors are your primary and best source of information regarding the plans they offer. Refer to the "Who to Contact" section for their telephone numbers and Web site addresses.

WHEN WILL I RECEIVE NEW INSURANCE ID CARDS?

- New CIGNA Medical ID cards will be issued to all enrollees for all medical plans, except for current enrollees in the Choice Fund HSA plan. CIGNA issues an individual ID card for each enrollee.

- New ID cards will be issued to new enrollees in the pharmacy or vision benefit, and EDS or Delta Dental plans. The ID cards from these vendors either 1) contain the names of all covered dependents or 2) contain only the insured's name and can be used for all covered dependents.

- There are no personalized ID cards for Magellan Health Services or CIGNA Dental. These ID cards are available through the Employee Health Initiatives Department.



CHOOSING THE PLAN THAT SUITS YOU

Maricopa County is committed to promoting better health for its employees and their families by continually evaluating our employee health benefits. Furthermore, Maricopa County continually looks for innovative solutions that will help all of us effectively control short and long-term health care costs without sacrificing the quality of health care you and your family deserve. We believe that by providing a wide selection of medical insurance benefit options every employee has the opportunity to choose the **"right plan"** for their family.

To help you decide what medical plan is **"right for you"**, please consider the following questions in the tables below. Table A is specific to the High Deductible Health Plan (HDHP) with Health Savings Account benefit option, and Table B applies to all managed care medical options. Please take the time to review both tables and review the plans for which you are interested.

TABLE A - IS THE CHOICE FUND HEALTH SAVINGS ACCOUNT BENEFIT OPTION RIGHT FOR YOU?	
Do you consider yourself to be healthy?	Yes / No
Do you enjoy managing and investing your money in programs like Deferred Compensation or other investments vehicles and watching the balance grow over the years?	Yes / No
Are you interested in having funding available to help save for future qualified medical and retiree health expenses on a tax-free basis?	Yes / No

If you answered Yes more than twice, please turn to the Medical Plan Summary Chart for more information on the CIGNA Choice Fund HSA plan benefit option.

TABLE B - FIND THE MEDICAL PLAN THAT'S BEST FOR YOU!	
Will you and/or your covered dependents live outside of Maricopa County during the plan year?	**Plans**
The OAP High and Low options as well as Choice Fund HSA offer out-of-network benefits and national networks of providers. The OAP In-Network option uses a national network of providers.	OAPIN OAP High OAP Low HSA
Do you like to use the CIGNA Medical Centers exclusively for your primary care needs?	
If you enjoy the convenience of receiving your primary medical care through a CIGNA Medical Center (owned and operated by CIGNA), you may want to consider the CMG High or Low benefit options.	CMG High CMG Low
Do you prefer lower out-of-pocket costs (copays and co-insurance) when deciding which medical benefit option to choose?	
Lower out-of-pocket costs, such as copays, mean that your per paycheck deduction will be higher. CMG High and OAP In-network benefit options offer lower copays.	CMG High OAPIN
Are your doctors and hospitals covered under the medical benefit option you choose?	
For all benefit options, CIGNA contracts with a variety of medical providers for different services that includes doctors, hospitals, laboratories, etc. Some benefit options offer larger networks that includes private practice primary care physicians and national networks to cover out-of-area services. The OAP In-network, OAP Low, OAP High and CIGNA Choice Fund HSA benefit options offer large provider networks.	OAP Low OAP High OAPIN HSA
Do you like having the flexibility of seeing providers who are outside of the plan's network?	
The OAP Low, OAP High and Choice Fund HSA benefit options offer coverage of providers who are not in the plan's network.	OAP High OAP Low HSA
Is having direct access to network providers without a referral important to you?	
For the OAP In-Network, OAP Low, OAP High and Choice Fund HSA benefit options, NO referrals to network specialists or PCP designation is necessary.	OAPIN OAP High OAP Low HSA

MEDICAL PLAN SUMMARY CHART

Benefit Provision	CIGNA Medical Group High (CMG High):	CIGNA Medical Group Low (CMG Low):	Open Access Plus In-Network (OAPIN):
Type of Plan	***HMO***	***HMO***	***HMO*** with Open Access to Specialists
Service Area Where Care Must be Received	Maricopa County only, except for emergency care	Maricopa County only, except for emergency care	Nationally
Residency Requirement	Must work or reside in Maricopa County	Must work or reside in Maricopa County	None
Primary Care Physician (PCP) Required	Yes; May only use PCP's who practice in CIGNA Medical Group Centers	Yes; May only use PCP's who practice in CIGNA Medical Group Centers	No
Referral Required	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine	No
Out-of-Network Coverage	No	No	No
Network	AZ-CIGNA Medical Group Network AZ812	AZ-CIGNA Medical Group Network AZ812	National Open Access Plus AZ300
Prior Authorization	Provider's responsibility	Provider's responsibility	Provider's responsibility

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

MEDICAL PLAN SUMMARY CHART

Benefit Provision	Open Access Plus High (OAP High):	Open Access Plus Low (OAP Low):	Choice Fund-HSA[1]:
Type of Plan	***HMO*** with Open Access to Specialists	***HMO*** with Open Access to Specialists	***High-deductible PPO*** plan with partially funded Health Savings Account[1]; cant' be enrolled in any other type of medical insurance
Service Area Where Care Must be Received	Nationally	Nationally	Nationally
Residency Requirement	None	None	None
PCP Required	No	No	No
Referral Required	No	No	No
Out-of-Network Coverage	Yes	Yes	Yes
Network	National Open Access AZ300	National Open Access AZ300	National Preferred Provider Network AZ011
Prior Authorization	Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.	Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.	Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.

[1]Maricopa County contributes $500 for employee only or $1,000 for employee and dependent coverage to your HSA pro-rated by the number of months remaining in the plan year. You can contribute up to $2,400 (individual) or $4,800 (family) to your HSA, plus $900 catch-up if over 55. Unused balances rollover.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		CIGNA Medical Group High (CMG High):	CIGNA Medical Group Low (CMG Low):	Open Access Plus In-Network (OAPIN):
		In-Network Coverage Only		
Deductible	Individual	None	None	None
	Family	None	None	None
Standard Percent of Co-insurance		N/A	90%	N/A
Out-of-Pocket Maximum	Individual	$1,000	$5,000	$1,000
	Family	$2,000	$10,000	$2,000
Pre-existing Condition Limitation		None	None	Yes, same as for OAP High & Low Options
Preventive Care		$0 (FREE)	$0 (FREE)	$0 (FREE)
Primary Care Physician Services		$15	$25	$20
Specialty Care Physician Services		$25* / $40	$45* / $60	$30* / $45
Advanced radiology: CT, PET, MRI, MRA Scans/type of scan/day and nuclear cardiac studies**		$50	$100	$100
Allergy Injections		$8* / $23	$13* / $28	$10* / $25
Outpatient Lab and X-ray		$0	$0	$0
Inpatient Facility Charges		$100/admit	$500/admit, then 10%	$200/admit
Inpatient Physician and Surgeon's Services		$0	$0	$0
Outpatient Facility Services		$0	$250, then 10%	$100
Pre- & Postnatal Exams (after pregnancy has been determined)		$25, waived after 1st visit	$45, waived after 1st visit	$30, waived after 1st visit
Delivery		$100	$500, then 10%	$200
Urgent Care		$35, waived if admitted	$50, waived if admitted	$50, waived if admitted
Emergency Room		$125, waived if admitted	$125, waived if admitted	$125, waived if admitted
Ambulance		$0	$0	$0
Durable Medical Equipment **No annual limit**		$0	$0	$0
External Prosthetics		$0	$0	$0
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 120 visits maximum combined/yr.		$25/provider/day***	$45/provider/day***	$30/provider/day
Cardiac Rehab; 36 visits/yr.		$25 per visit	$45 per visit	$30 per visit
Alternative Medicine; 20 visits/yr. $60 credit for supplies/products		$15 per visit	$25 per visit	$20 per visit
Behavioral Health/Pharmacy		Magellan/WHI	Magellan/WHI	Magellan/WHI

For more detail, review the medical plan summaries on the CIGNA tab of the EHI Web site ***www.maricopa.gov/benefits***.

*CIGNA Care Network Specialist

**Advanced radiology copays apply in addition to inpatient, outpatient and emergency room copays or co-insurance.

***Chiropractic visits have a separate 60 visit limit per year. Other therapies have a combined 60 visit per year.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Open Access Plus High (OAP High):		Open Access Plus Low (OAP Low):		Choice Fund-HSA:	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
None	$500	None	$1,000	$1,200 (cross accumulated)	$1,200 (cross accumulated)
None	$1,000	None	$2,000	$2,400 (cross accumulated)	$2,400 (cross accumulated)
N/A	70% of reasonable and customary	90%	70% of reasonable & customary	90%	70% of reasonable & customary
$1,500	$3,000	$5,000	$10,000	$2,000 (cross accumulated)	$2,000 (cross accumulated)
$3,000	$6,000	$10,000	$20,000	$4,000 (cross accumulated)	$4,000 (cross accumulated)
12 months for treatment in prior 60 days. Waived with certificate of creditable coverage and for employees currently covered by a county medical plan for at least 12 months. Certificate of creditable coverage must be sent to CIGNA and also provided to the EHI Department.					
$0 (FREE)	Covered in-network only	$0 (FREE)	Covered in-network only	$0 (FREE)	Covered in-network only
$25	30% after deductible	$35	30% after deductible	10% after deductible	30% after deductible
$35* / $50	30% after deductible	$50* / $65	30% after deductible	10% after deductible	30% after deductible
$100	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
$13* / $28	30% after deductible	$18* / $33	30% after deductible	10% after deductible	30% after deductible
$0	30% after deductible	10%	30% after deductible	10% after deductible; $0, no deductible if preventative	30% after deductible
$250/admit	30% after deductible	$1,000/admit, then 10%	$2,000/admit, then 30%	10% after deductible	30% after deductible
$0	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
$100	30% after deductible	$500, then 10%	$1,000/admit, then 30% after deductible	10% after deductible	30% after deductible
$35, waived after 1st visit	30% after deductible	$50, then 10%	30% after deductible	10% after deductible	30% after deductible
$250	30% after deductible	$1,000, then 10%	$2,000, then 30% after deductible	10% after deductible	30% after deductible
$50, waived if admitted	$50, waived if admitted	$75, waived if admitted	$75, waived if admitted	10% after deductible	10% after deductible
$125, waived if admitted	$125, waived if admitted	$150, waived if admitted	$150, waived if admitted	10% after deductible	10% after deductible
$0	$0	10%	10%	10% after deductible	10% after deductible
$0	30% after deductible	10%	30% after deductible	10% after deductible; No limit	30% after deductible; No limit
$0	30% after deductible	10%	30% after deductible	10%	30% after deductible
$35/provider/day	30% after deductible/ provider/day	$50/provider/day	30% after deductible/ provider/day	10% after deductible/ provider/day	30% after deductible/ provider/day
$35 per visit	30% after deductible	$35 per visit	30% after deductible	10% after deductible	30% after deductible
$25 per visit	Covered in-network only	$35 per visit	Covered in-network only	$15 per visit	Covered in-network only
Magellan/WHI	Magellan/WHI	Magellan/WHI	Magellan/WHI	CIGNA Behavioral Health/CIGNA Pharmacy	

For more detail, review the medical plan summaries on the CIGNA tab of the EHI Web site ***www.maricopa.gov/benefits***.

*CIGNA Care Network Specialist

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PHARMACY PLANS

Administered by Walgreens Health Initiatives (WHI)

If you enroll in a medical plan, except for the Choice Fund HSA plan, you must enroll in one of the pharmacy plans below. However, you may not enroll your dependents in a pharmacy plan if they are not enrolled in your medical plan.

Co-insurance Benefit Plan

The Co-insurance benefit is a five-level plan in which a co-insurance amount (percentage of the cost[1] of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication. This plan covers generic, preferred brand-name, non-preferred brand-name and specialty medication. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility and cosmetic medications, are excluded. You are responsible for paying 100% of the contracted cost for excluded medications.

You will be charged the minimum or maximum copay or the co-insurance amount for the medication, based on the medication's level and cost. If you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost between the medications.

The co-insurance or the minimum or maximum copay you pay toward any covered medication apply to your out-of-pocket maximum except when a non-preferred brand name medication with a generic equivalent is purchased, the difference between the brand and the generic equivalent will not count. The out-of-pocket limit is $1,500 for an individual and $3,000 for a family[2]. Once the out-of-pocket limit is met, covered medications are paid 100% by the plan for the remainder of the plan year, except for the difference between the non-preferred brand and it's generic equivalent, which will continue to be your responsibility.

Annual Out-of-Pocket Maximum $1,500 Single / $3,000 Family[2]				
	Classification	**Up to 30-Day Supply**		
Level 1	Generic	$2 Minimum	25% Co-insurance[1]	$12 Maximum[3]
Level 2	Preferred Brand	$5 Minimum	30% Co-insurance[1]	$30 Maximum[3]
Level 3	Non-Preferred Brand with Generic equivalent	$20 Minimum	50% Co-insurance[1] +	Difference between brand & generic cost
Level 4	Non-Preferred Brand with No Generic equivalent	$20 Minimum	50% Co-insurance[1]	
Level 5	Non-Preferred Brand Specialty Drugs	$50 Copay		

[1] Cost of medication is calculated by average wholesale price - discount or maximum allowable cost + dispensing fee. Discount amount varies by place of service and number of days supplied. To find the lowest cost for medication between retail, Advantage90™ and mail service, go to ***www.mywhi.com***

[2] Family refers to employee and one or more covered dependents.

[3] Maximums are reduced when mail service is used.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

Contact Walgreens Health Initiatives for additional information, or view the detailed ***Pharmacy Summary Plan*** document available on the EHI Web site at ***www.maricopa.gov/benefits***.

Consumer Choice Benefit Plan

The Consumer Choice Plan has four levels of coverage:

- Level 1 is a County funded pharmacy account. The County will place $300 in an Individual account or $500 in a Family account (family in this case is defined as more than 1 person covered). In terms of Family coverage, the $500 is available to whichever family members use the pharmacy benefit on a first come, first served basis and no one individual on a Family plan may exceed $300 of the allocated $500.
- Level 2 consists of the Employee deductible portion and begins when the $300 Individual or $500 Family amount in Level 1 is exhausted. Employees must then meet their deductible of $300 for an Individual or $500 for a Family before moving to the next level. Individuals insured under a Family plan who reach $300 of the $500 deductible are able to move to the Level 3 benefit while the rest of the family must remain at Level 2 until the additional $200 is met.
- Level 3 is more like your traditional insurance coverage where the County pays 80% of the cost of the medication and you pay 20% of the cost for the remainder of the benefit year.
- Level 4 is limited to specialty medications only and consists of a $50 copayment. Specialty medication copayments are not charged against any of the first 3 levels.

For further clarification on the Consumer Choice Pharmacy Plan, please refer to the Pharmacy Benefit Plan booklet found at: ***www.maricopa.gov/benefits***.

The Consumer Choice benefit is geared towards smart spending through the use of the most cost-effective medication. A preferred medication list (PML) is not used to manage this benefit because much of the management is up to you. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, cosmetics, smoking cessation and non-steroid anti-inflammatory medications are excluded.

The amounts you pay toward any covered medication will apply to your plan year out-of-pocket maximum. The out-of-pocket maximum is $1,500 for individual coverage or $3,000 for family[2] coverage. Once the out-of-pocket maximum is met, covered prescriptions are paid 100% by the plan for the remainder of the plan year.

<table>
<tr><th colspan="6">Annual Out-of-Pocket Maximum
$1,500 Single / $3,000 Family[2]</th></tr>
<tr><td></td><td colspan="5">Certain generic preventive medications are provided at no cost. List available at www.maricopa.gov/benefits.</td></tr>
<tr><td>Level 1</td><td>Pharmacy Account</td><td>Individual
Family[2]</td><td>$300 Individual
$500 Family</td><td>100% Employer paid[1]</td><td>Any unused amount is carried over to next plan year</td></tr>
<tr><td>Level 2</td><td>Employee Responsibility</td><td>Individual
Family[2]</td><td>$300 Individual
$500 Family</td><td colspan="2">100% Employee paid[1]</td></tr>
<tr><td>Level 3</td><td>Traditional Insurance Coverage</td><td colspan="2"></td><td>20%[1] covered by Employee</td><td>80%[1] covered by Employer</td></tr>
<tr><td>Level 4</td><td>Specialty Drug</td><td colspan="4">$50 copay; does not apply to pharmacy account, employee responsibility or insurance levels; Copay applies to out-of-pocket maximum.</td></tr>
</table>

[1] Cost of medication is calculated by average wholesale price - discount or maximum allowable cost + dispensing fee. Discount amount varies by place of service and number of days supplied. To find the lowest cost for medication between retail, Advantage90™ and mail service, go to ***www.mywhi.com***

[2] Family refers to employee and one or more covered dependents.

[3] Maximums are reduced when mail service is used.

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Contact Walgreens Health Initiatives for additional information, or view the detailed ***Pharmacy Summary Plan*** document available on the EHI Web site at ***www.maricopa.gov/benefits***.

Co-insurance Benefit Plan & Consumer Choice Benefit Plan

THREE-MONTH SUPPLY AT CERTAIN RETAIL PHARMACIES – ADVANTAGE90™ When you need maintenance medications for chronic or long-term health conditions, you must purchase a three-month supply at any pharmacy located in a retail pharmacy participating in Advantage90™ or through mail service, after two fills of 30 or less days supply of a maintenance medication at a retail pharmacy. The physician must write your prescription for an 84-91 day supply. Refer to ***www.mywhi.com*** for a list of pharmacies participating in Advantage90™. Your cost for a three-month supply at an Advantage90™ retail pharmacy is may be slightly less than three times the one-month supply copay or co-insurance.

THREE-MONTH SUPPLY THROUGH THE MAIL SERVICE PHARMACY Prescriptions for maintenance medications or long-term health conditions can be ordered through the Walgreens Mail Service pharmacy. Besides being convenient, you could save more money! Maximum copayments and co-insurance for the Co-insurance plan are reduced when mail service is used. Level One (generic) has 15% co-insurance with a maximum of $28, and Level Two (preferred brand) has 25% co-insurance with a maximum of $70. For the Consumer Choice Plan, you may save money as many of the medications, especially generics, have a higher discounted contracted cost than medications filled at a retail or Advantage90™ pharmacy. You must use a specific order form when placing your first order so as to provide Walgreens Mail Service with important health, allergy and plan information. This form is called the Tempe Registration and Order Form and is available online at ***www.maricopa.gov/benefits*** or at ***www.mywhi.com***.

If purchasing medication in a three-month supply is financially problematic, please consider enrolling in the Choice Fund HSA medical plan that uses the CIGNA pharmacy plan and does not require you to purchase maintenance medication in three-month quantities.

Note: Diabetic supplies and medications may be obtained at a CIGNA Medical Group pharmacy for $10 per item for a 30-day supply. Please show your CIGNA ID card since these costs will be charged to your medical plan instead of your pharmacy plan.

CIGNA Pharmacy Plan for Choice Fund HSA Plan

If you enrolled in the Choice Fund HSA Medical plan, your pharmacy benefit is provided through CIGNA instead of WHI. The CIGNA plan consists of a three-level co-insurance plan.

CIGNA Pharmacy Plan for Choice Fund HSA Plan

Level 1	Generic	30% after deductible
Level 2	Preferred Brand	40% after deductible
Level 3	Non-Preferred Brand	50% after deductible
Certain generic and preferred brand preventive medications are provided at no cost (Deductible does not apply to these preventive medications).		

Cost of pharmacy plan included in medical premium for Choice Fund HSA plan
Refer to ***www.cigna.com*** for a list of medications by level.

The pharmacy benefit for Choice Fund HSA is administered by:

CIGNA

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VISION PLAN

Administered by EyeMed Vision Care

If you enroll in any County medical plan, you must enroll (cannot waive) in the vision benefit. The County also offers this plan as a separate (stand-alone) vision plan for employees who choose to waive their medical benefits and wish to enroll in the vision plan. However, you may not enroll your dependents in a vision plan if they are not enrolled in your medical plan.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	$35
Exam Options:		
Standard Contact Lens Fit and Follow-Up*	Up to $55	N/A
Premium Contact Lens Fit and Follow-Up**	10% off retail price	N/A
Frames:		
Any available frame at provider location	$130 allowance, 20% off balance over $130	$50
Standard Plastic Lenses:		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lenticular	$10 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$0	$25
Standard Anti-Reflective Coating	$45	N/A
Standard Progressive (Add-on to Bifocal)	$65	N/A
Other Add-ons and Services	20% off retail price	N/A
Contact Lenses: (Contact lens allowance covers materials only)		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$130
Disposable	$0 Copay, $130 allowance, plus balance over $130	$130
Medically Necessary	$0 Copay, Paid-in-Full	$250
Laser Vision Correction	$150 allowance; once per lifetime per eye	N/A
Frequency:		
Examination	Once every 12 months	
Frame	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)

**Premium Contact Lens Fitting - all lens designs, materials and speciality fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)

Additional Discounts:

Member will receive a 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision.

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at ***www.eyemedvisioncare.com***. The contact lens benefit allowance is not applicable to this service.

DENTAL PLAN SUMMARY CHART

Benefit Provision	EDS	CIGNA Dental	Delta Dental
Type of Plan	***DCO*** (Dental Care Organization)	***PPO***	***PPO*** (but does not use PPO network; see network below.)
Service Area Where Care Must be Received	Maricopa County	Nationally	Nationally
Residency Requirement	No	No	No
Primary Care Dentist Required	Yes, all family members must choose the same dentist	No	No
Referral Required	No	No	No
Out-of-Network Coverage	No	Yes	Yes
Network	EDS Provider Network	CIGNA Dental Network	Delta Premier Network
Prior Authorization	No	No, predetermination recommended for services over $250	No, predetermination recommended for services over $250
Location of Provider Directory	***www.mydentalplan.net***	***www.cigna.com***	***www.deltadentalaz.com***

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DENTAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		EDS*	CIGNA Dental***		Delta Dental	
		In-Network coverage only	In and Out-of-Network coverage			
Deductible	Individual	$0	$50		$50	
	Family	$0	$100		$100	
Annual Individual Benefit Maximum	Standard	None	$2,000		$2,000	
	Orthodontic	None	$3,000		$3,000	
Pre-existing Condition Limitation		Procedures in progress at time of enrollment are not covered	5 year waiting period for replacement (major services)		5 year waiting period for replacement (major services)	
Class I - Preventive Care Services			**Amount Paid by the Member**			
Preventive Care		$0	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Routine Cleanings			Deductible waived			
Sealants		$12/tooth	$0	20%	$0	$0
Space Maintainers		$20 + lab fees				
Diagnostic		Copay $0-$20	Deductible waived			
Exams			$0	20%	$0	$0
Evaluations						
Consultations & X-rays						
Emergency		Up to $200 reimbursement less applicable copay	Deductible waived			
Palliative Treatment			$0	20%	$0	$0
Treatment for the relief of pain						
Class II - Basic Restorative Services			**Amount Paid by the Member**			
Restorative		Amalgam $8-$21	Amalgam 20%	Amalgam 40%	Amalgam 20%	Amalgam 20%
Fillings		Resin $22-$40	Resin 50%	Resin 50%	Resin 50%	Resin 50%
Oral Surgery		From $35	20%	40%	20%	20%
Extractions						
Endodontics		Copay $170-$265	20%	40%	20%	20%
Root Canal Treatment						
Pulpotomy						
Periodontics		Debridement: $80	20%	40%	20%	20%
Treatment of gum disease		Root Planing: $90				
Periodontal Maintenance						
Bridge & Denture Repair		$10 + lab fees	20%	40%	20%	20%
Class III - Major Restorative Services			**Amount Paid by the Member**			
Prosthodontics			50%		50%	
Bridges per pontic		$250 + lab fees				
Partial Dentures		$375 + lab fees				
Complete Dentures (upper or lower)		$325 + lab fees				
Restorative			50%		50%	
Cast Crowns & Jackets		$250 + lab fees				
Onlays & Inlays		$135 - $170				
Class IV - Orthodontic Services			**Amount Paid by the Member**			
Orthodontic maximum is separate from annual benefit maximum		25% discount children & adults	50% children & adults		50% Adults & children age 8 + older	

*Specialist Care & treatment of TMJ are offered at a discount.

**If the dentist charges more than the reasonable & customary allowance, you will be liable for the difference between the allowance and the billed amount in addition to the applicable deductible and co-insurance.

*** Progressive/Regressive Base Plan. If you enroll in this plan, if you receive a preventive service during FY 08-09 plan year you increase your level of coverage for the next plan year.

For more detail, review the dental plan documents at ***www.maricopa.gov/benefits***.

HOW TO LOOK UP A PHYSICIAN OR DENTIST ONLINE

CIGNA Medical and Dental Plans – Start at www.cigna.com

1. From the home page, select the Provider Directory link (at top of screen)
2. For medical, enter your physician search information
   For dental, select the radio button next to Dentist and enter the search information
3. Click on the "Next" button
4. Continue with the applicable instructions below

Remember to look for the Tree of Life symbol to identify CIGNA Care Network Specialists for a lower copay.

CMG High and Low Options use the AZ – CIGNA Medical Group Network AZ812

1. On the next page, under "What type of plan you have" section, choose "Network (HMO) Plans or Point of Service (POS) Plans"
2. From the "Network (HMO) Plans or Point of Service (POS) Plans" drop-down list, select AZ-CIGNA Medial Group
3. Under "What you're looking for" section, select "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list
4. Click on the "Search" button to view the provider search response

OAP In-Network and OAP High and Low Options use the National Open Access Plus Network AZ300

1. On the next page, under the "What type of plan you have" section, choose "Open Access Plus Only"
2. Under "What you're looking for" section, select "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list
3. Click on the "Search" button to view the provider search response

Choice Fund Health Savings Account (HSA) use the National Preferred Provider Network AZ011

1. On the next page, under "What type of plan you have" section, choose "Preferred Provider Organizations (PPO)"
2. Under "What you're looking for" section, select a physician listed under the "Specialist" area and the type from the corresponding drop-down list
3. Click on the "Search" button to view the provider search response

CIGNA Dental

On the next page, under "What type of plan you have" section, choose "Managed care plan with open access to dentists for CIGNA Dental PPO" and the type from the drop-down list. Click on the "Search" button to view the dental search response.

Other Dental Plans

EDS

1. Start at ***www.mydentalplan.net***
2. From the Home page, under the Members Tool section, click on the "Dentist Search" link
3. You can search by city, dentist's last name or download a provider directory

Delta Dental

1. Start at ***www.deltadentalaz.com***
2. Click on Dentist and then Dentist Search
3. When a new page appears, under "1. Product Selection", select "Dental Premier" and continue entering the identifying information
4. Or call 602-938-3131 and select 5 and enter the zip code to hear a listing of dentists in your area

COMBINED RATE SHEET

Monthly Total Rates for Non-Tobacco Users
(Medical, pharmacy, behavioral health, vision)
Add $30.60 per household for tobacco-users (employees and/or covered dependents)

Medical

CMG High option + Co-insurance Rx	Full-time
Employee	$429.75
Employee + Spouse	$865.82
Employee + Child(ren)	$713.14
Employee + Family	$1,151.34

CMG High

CMG High option + Consumer Choice Rx	Full-time
Employee	$385.11
Employee + Spouse	$776.55
Employee + Child(ren)	$639.58
Employee + Family	$1,033.14

CMG Low option + Co-insurance Rx	Full-time
Employee	$342.52
Employee + Spouse	$691.07
Employee + Child(ren)	$569.61
Employee + Family	$919.80

CMG Low

CMG Low option + Consumer Choice Rx	Full-time
Employee	$297.88
Employee + Spouse	$601.80
Employee + Child(ren)	$496.05
Employee + Family	$801.60

OAP In-Network + Co-insurance Rx	Full-time
Employee	$433.50
Employee + Spouse	$872.22
Employee + Child(ren)	$718.69
Employee + Family	$1,159.54

OAPIN

OAP In-Network + Consumer Choice Rx	Full-time
Employee	$388.86
Employee + Spouse	$782.95
Employee + Child(ren)	$645.13
Employee + Family	$1,041.34

OAP High option + Co-insurance Rx	Full-time
Employee	$509.59
Employee + Spouse	$1,025.75
Employee + Child(ren)	$844.64
Employee + Family	$1,363.41

OAP High

OAP High option + Consumer Choice Rx	Full-time
Employee	$464.96
Employee + Spouse	$936.48
Employee + Child(ren)	$771.08
Employee + Family	$1,245.22

OAP Low option + Co-insurance Rx	Full-time
Employee	$352.84
Employee + Spouse	$711.06
Employee + Child(ren)	$586.13
Employee + Family	$946.07

OAP Low

OAP Low option + Consumer Choice Rx	Full-time
Employee	$308.20
Employee + Spouse	$621.79
Employee + Child(ren)	$512.57
Employee + Family	$827.87

Choice Fund HSA + CIGNA Rx	Full-time
Employee	$393.03
Employee + Spouse	$792.62
Employee + Child(ren)	$652.43
Employee + Family	$1,054.64

Choice Fund HSA

Dental

EDS	Full-time
Employee	$10.20
Employee + Spouse	$19.38
Employee + Child(ren)	$25.46
Employee + Family	$29.34

CIGNA Dental	Full-time
Employee	$33.05
Employee + Spouse	$72.87
Employee + Child(ren)	$78.83
Employee + Family	$101.33

Delta Dental	Full-time
Employee	$41.62
Employee + Spouse	$91.80
Employee + Child(ren)	$99.27
Employee + Family	$127.62

Stand-Alone Vision

Stand-Alone Vision	Full-time
Employee	$9.87
Employee + Spouse	$18.60
Employee + Child(ren)	$19.50
Employee + Family	$28.64

WHAT HAPPENS IF I DON'T COMPLETE OPEN ENROLLMENT?

MEDICAL, DENTAL & PHARMACY

If you do not enroll, you and your current dependents will be enrolled in your current medical, dental, pharmacy and vision plans.

TOBACCO USER RATES

If you do not complete Open Enrollment, it will be assumed that your current status as a tobacco user is correct. Please note that the tobacco user rates apply not only to the employee but also to any covered dependent. **If you have a covered dependent who uses tobacco products and you do not, <u>you must</u> complete open enrollment to update this information.**

DISCLAIMER

Carefully read the information in this guide.

Do not make a medical or dental election solely on the basis of a healthcare provider's participation with the vendor's network because physicians and dentists may stop participating during the plan year.

If a specific physician or dentist is very important to you, consider selecting a product with out-of-network benefits such as an Open Access Plus (OAP) High or Low option or Choice Fund PPO medical plan and/or CIGNA or Delta Dental plans. Plans with out-of-network benefits allow you to see providers who no longer participate with the vendor's network, at higher out-of-pocket costs to you. Additionally, you should not make your pharmacy election solely on the basis of specific medications on the preferred medication list because medication coverage status may change during the plan year. For example, medications may change from preferred brand name level to a generic or non-preferred brand name level, or may become available over-the-counter and therefore will not be covered under the pharmacy benefit.

Make your election decisions carefully as they cannot be changed until July 1, 2009.

Once all enrollment elections are processed by the COBRA Administrator, payment coupons will be mailed to you by mid-June.

Keep a copy of your enrollment form as verification of your Open Enrollment elections. Review your payment coupons carefully and contact your COBRA Administrator by June 30, 2008 if you discover an error.

Watch for your new ID card in the mail and upon receipt, be sure to check the PCP. After July 1, 2008, contact your selected medical plan vendor to change your primary care provider (PCP), if applicable. Destroy your old ID card upon receipt of your new card. If additional cards are needed, contact the vendor directly either by phone or through their Web site. See the "Who to Contact" section.

WHO TO CONTACT

Maricopa County Employee Health Initiatives Department
(Benefits Office)
Maricopa County Administration Building
301 West Jefferson St., Suite 201
Phoenix, Arizona 85003-2145
(602) 506-1010
Fax: (602) 506-2354
TTY: (602) 506-1908
EHI Web site: ***www.maricopa.gov/benefits***
EHI email: ***BenefitsService@mail.maricopa.gov***

Medical Plans

CIGNA - Group #3205496
Customer Service - (800) 244-6224
Pre-Enrollment Questions - (800) 401-4041
24-Hour Health Information Line - (800) 564-8982
www.cigna.com
www.mycigna.com

*Pharmacy Plans**

Walgreens Health Initiatives - Group #512229
Member Services - (800) 207-2568
Prior Authorization - (877) 665-6609
Walgreens Mail Service Member Service - (888) 265-1953
Mail Service Refills - (800) 797-3345
Specialty Pharmacy - (888) 782-8443
www.mywhi.com

*Behavioral Health**

Magellan Health Services - Group# N/A
(888) 213-5125
www.magellanhealth.com

Vision

EyeMed Vision Care - Group #9690793
Customer Service - (866) 724-0782
Pre-Enrollment Questions - (866) 723-0596
LASIK - (877) 552-7376
www.eyemedvisioncare.com
emvision@eyemed.sento.com

Dental

Employers Dental Services - Group #11931-Plan #300R
(602) 248-8912 or (800) 722-9772
www.mydentalplan.net

CIGNA Dental - Group # 2465354
(888) 336-8258
www.mycigna.com

Delta Dental - Group # 4500
(602) 938-3131 or (800) 352-6132
www.deltadentalaz.com

*Contact CIGNA for pharmacy & behavioral health for the Choice Fund HSA plan

Retirement

Arizona State Retirement System - (602) 240-2000
Outside Phoenix - (800) 621-3778
www.azasrs.gov/web/index.do

Public Safety Retirement System
(602) 255-5575
www.psprs.com

Nationwide Retirement Solutions:
Deferred Compensation
(602) 266-2733
(800) 598-4457
www.maricopadc.com

COBRA

Compusys
COBRA Administrator
(800) 933-7472
mccobra@cserisa.com